PRINTED: 03/31/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPI	
		155095	B. WIN	G		02/24/2	2011
NAME OF I	PROVIDER OR SUPPLIEI	2		STREET	ADDRESS, CITY, STATE, ZIP CODE		
TVI WILL OF 1	ROVIDER OR SOLITEIE			1	OBSON ROAD		
HERITAG	GE PARK			FORT \	WAYNE, IN46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	This visit was fo	or a Recertification and	F00	00	The ceation and submission of	of	
	State Licensure	Survey			this Plan of Corrction does no		
					constitute an admission by th		
Survey dates: 2011		ebruary 21, 22, 23, & 24,			provider of any conclusion se forth in the statement of	τ	
		21, 22, 23, 66 2 1,			deficiencies, or of any violation	n of	
	2011				regulation.This provider		
	   Facility number:	000038			respectfully requests that the		
	Provider number				2567L Plan of Correction be considered the Letter of Cred	ihle	
AIM number:					Allegation.Based on past surv		
	7 Hill Hamoor.	0027 1030			history and no harm identified	•	
	Survey team:				any resident; this facility		
	Rick Blain, RN	TC			respectfully requests a desk	, on	
	Sue Brooker, RI				review in lieu of a post-survey or after March 18, 2011	, ou	
	Christine Fodrea				or arter maron 10, 2011		
	Timothy Long, I						
	Angela Strass, R						
	1						
	Julie Wagoner, F	XIV					
	Census bed type						
	SNF/NF: 146	•					
	SNF: 27						
	Total: 173						
	10ta1. 173						
	Census payor ty	ne:					
	Medicare: 32	pe.					
	Medicaid: 92						
	Other: 49						
	Total: 173						
	Sample: 26						
		1 0 0					
		es also reflect State					
	L findings in accou	rdance with 410 IAC 16.2	ı		I		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5FNP11

Facility ID:

000038

TITLE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. E			A. BUILDING B. WING	I 02/24/2011			
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COI OBSON ROAD	DE		
HERITA	AGE PARK			WAYNE, IN46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	Quality review of Jennie Bartelt, F	completed 3/3/11 by RN.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155095	B. WIN			02/24/2011	
NAME OF I	DOLUMEN OF GLIPPI HER		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIER			2001 H	OBSON ROAD		
HERITAC					WAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG	F272 COMPREHENSIVE	DATE	
F0272	Based on reco	rd review and	F02	12	ASSESSMENTSIt is the practi	03/18/2011	
SS=D	interview, the facility failed to				of this provider to ensure a		
	assess a declin	e in bowel			comprehensive, accurate,		
	continence for	3 of 9 residents			standardized reproducible		
		ncontinence in a			assessment is conducted initial and periodically for each	ally	
					resident's fuctional capacity.		
	*	(Residents #60, 67,			However; based on the allege	d	
	and 82)				deficient practice- the following	9	
					has been implemented:What		
	Finding includ	les:			corrective actions(s) will be accomplished for those reside	nte	
					found to have been affected by	I	
					the deficient practice:Resident		
	During the init				#60 A bowel assessment has		
	facility, condu	cted on 02/21/11			been completed for this		
	between 10:15	6 A.M 11:00 A.M.,			residentResident #67 A bowe assessment has been completed.		
	LPN #6 indica	ted Resident #60, 67,			for this residentResident #82	I	
		ll incontinent and			bowel assessment has been		
		sive staff assistance			completed for this residentHov	I	
	-				will you identify other residents having the potetial to be affect		
	, , ,	d toileting needs.			by the same deficient practice		
	She indicated	Residents #60 and			and what corrective actio will b		
	#82 were toile	ted and Resident #67			taken:No other residents were		
	was usually pl	aced on a bedpan.			foud to have been affected by alleged deficient	tne	
	, J F-	· <b>r</b> ··			practiceResidents experiencin	ga	
	1 The elimina	1 record for Desident			change in bowel continence ha		
		l record for Resident			the potential to be affected by	the	
		wed on 02/23/11 at			alleged deficient practiceThe		
	10:07 A.M. T	he most recent full			MDS Department will notify the Unit Manager of residents with		
	MDS (Minimu	ım Data Set)			change in bowel continence pe	I	
	,	ompleted on 06/10/10,			completion of the MDSThe Un	it	
		esident was usually			Manager/Designee will comple	I	
		•			a bowel assessment to assist identifying the causative factor		
	continent of ne	er bowels. However,			the change in continenceThe	·	
					!	<u> </u>	

000038

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155095	B. WIN			02/24/2011	
NAME OF I	DROVIDED OD GUDDU IED			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			2001 H	OBSON ROAD		
	GE PARK				WAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
IAG	•	at quarterly MDS		IAG	bowel assessment will be	DAIL	
		ompleted on 11/30/10,			reviewed by the IDT at which to a note will be written and the	time	
	indicated the resident had declined and was now frequently incontinent				careplan updated with any		
					identified changesThe MDS Department and Nurse		
	of her bowels.				Management have been		
					educated on this process.		
2. The clinical record for Resident					Education includes but is not limited to MDS notifying the U	nit	
	#67 was review	wed on 02/22/11 at			Manager of change in bowel continence, completion of the		
	9:15 A.M. Th	e most recent full			bowel assessment, appropriat	e l	
	MDS assessme	ent, completed on			documentation in the IDT note	:	
		cated the resident was			and updating the individual plate of careEducation provided Ma		
		ontinent of her			17, 2011 by the Director of		
	1 1	ever, the most recent			Nursing ServicesThe DNS/AD	NS	
	MDS review,	· ·			is responsible for oversight to ensure complianceWhat		
		ated the resident had			measures will be put into place		
		vas now totally			what systemic changes you w make to ensure that the deficient	I	
	incontinent of				practice dows not recur:No oth		
		nei doweis.			residents were foud to have be	I	
	2 771 1: :	1 1 C D 11 4			affected by the alleged deficie practiceResidents experiencin		
		l record for Resident			change in bowel continence h	- 1	
		wed on 02/21/11 at			the potential to be affected by		
		e most recent full			alleged deficient practiceThe MDS Department will notify th	e	
		ent, completed on			Unit Manager of residents with		
	08/18/10, indi	cated the resident was			change in bowel continence p		
	usually incont	inent of her bowels.			completion of the MDSThe Ur Manager/Designee will complete		
	However, the most recent MDS				a bowel assessment to assist		
	review assessr	nent, completed on			identifying the causative factor	rof	
	02/04/11 indicated the resident had				the change in continenceThe bowel assessment will be		
	declined and w	vas now frequently			reviewed by the IDT at which	time	
		1			a note will be written and the		

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/24/2011		
	PROVIDER OR SUPPLIEF	<b>!!</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON ROAD  FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	assessment income for Resident # Interview with Nursing, on 02 A.M., indicate policy to assess and no assessing the session of	bowel incontinence dicated in the records		careplan updated with any identified changesThe MDS Department and Nurse Management have been educated on this process. Education includes but is not limited to MDS notifying the Umanager of change in bowel continence, completion of the bowel assessment, appropria documentation in the IDT not and updating the individual p of careEducation provided M 17, 2011 by the Director of Nursing ServicesThe DNS/A is responsible for oversight to ensure complianceHow the corrective action(s) will be monitored to ensure the defic practice will not recur: A CQI monitoring tool titled "Bowel Elimination" will be utilized evek x 4, monthly x 3 and quarterly thereafterData will be developedNon-compliance w facility procedure may result disciplinary action up to and including termination Comple Date: March 18, 2011	Unit e ate de		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155095	B. WIN			02/24/2	011
NAME OF F	ADOLUDED OD GUDDU IED			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2001 H	OBSON ROAD		
HERITAG					WAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
F0279	Based on reco	<u> </u>	F02		F279 DEVELOP		03/25/2011
			102	1)	COMPREHENSIVE CARE		03/23/2011
SS=D	interview, the facility failed to				PLANIt is the practice of this		
	•	individualized care			provider to ensure the results the assessment are used to	of	
	plan regarding	toileting to address			develop, review and revise the	,	
	bladder incont	inence for 2 of 9			resident's comprehensive plan		
	residents revie	ewed for incontinence			care. However; based on the		
		26. (Residents #174			alleged deficient practice- the following has been		
	and 60)	20. (Residents #17)			implemented:What corrective		
	and oo)				action(s) will be accomplished	for	
Findings include:					those residents found to have		
		de:			been affected by the deficient practice:Resident #174 This		
					resident no longer resides at the	nis	
	1. The closed	clinical record for			facilityResident #60 The		
	Resident #174	was reviewed on			resident's voiding diary has be reviewed. The resident is on a		
	02/23/11 at 1:4	45 P.M. The resident			individualized toileting program		
		itted to the facility on			(Program #1) and the plan of o	care	
		gnoses included, but			has been updated to reflect the		
		_			change.How will you identify o residents having the potential		
		ed to, end stage renal			be affected by the same defici		
		tension, and chronic			practice and what corrective		
	obstructive res	spiratory disease.			action will be taken:No other residents were found to have		
					been affected by the alleged		
	The initial Min	nimum Data Set			deficient practiceResidents wit	th	
	(MDS) assessi	ment, completed on			urinary incontinence have the		
	` ′	cated the resident was			potential to be affected by the alleged deficient practiceUpon		
	mildly cognitive				completion of the 3-day voiding		
	, ,				diary the Restorative Nurse		
	_	sive staff assistance			reviews continent and incontin episodes and assigns the	ent	
	for hygiene and toileting needs, and				appropriate Toileting Program		
	was always in	continent of his			based on the diary results. Th	ie	
	bladder.				careplan is updated and	:	
					individualized using the identif	iea	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/24/2011	
NAME OF I	PROVIDER OR SUPPLIER	<b>!!</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON ROAD  FORT WAYNE, IN46805				
	SUMMARY S (EACH DEFICIENT REGULATORY OR PREGULATORY	examinate to the second not ge to urinate, could nanage to ileting usting his clothes eting, or utilize a call ident's fistula for nents was indicated as factor to the ntinence, and a lder incontinence was ne assessment form.		GSTREET A	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)  appropriate Toileting Program Restorative Nurse has been re-educated on this provider's Toileting Programs for bladder incontinence. Education inclubut is not limited to assessing 3-day voiding diary including identifying patterns, assigning appropriate Toileting Program individualizing/updating the plof care. Education provided Miditary 17, 2011 by the Director of Nursing Services The facility toileting program has been modified to ensure there is no extended period of time between toileting opportunities. The modified toileting program allot that residents appropriate for Toileting Plan #2 will be toileted before or after meals using the following guideline:1. Resident are toileted upon rising in the A.M.2. Residents residing in a "even" numbered room are toileted before each meal3. Residents residing in an "odd" numbered room are toileted at HS5. Residents are checked every 2 hours through the night. The Modifier Toileting Program Education when provided to nursing staff	The The The the and an arch een bws ed eents an ee dare e	(X5) COMPLETION DATE
The assessment concluded the resident was not mentally or physically aware of the need to void and able to utilize the toilet and could not resist the urge to void.					through March 25, 2011 by the Director of Nursing Services/DesigneeThe DNS/ADNS is responsible for oversight to ensure compliance. What measures we be put into place or what systems.	<i>i</i> ill	

NAME OF PROVIDER OR SUPPLIER  HERITAGE PARK  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  A 3 day voiding pattern was completed on 10/16/10 - 10/18/10 Both patterning records indicated the resident was able to void correctly in the toilet several times during the day, with at least 3 times noted between 7:00 A.M 12:00 PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5) COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREVIX TAG  PROVIDERS PLAN OF CORRECTION (X5) COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG  Changes you will make to ensure that the deficient practice does not recur: Upon completion of the 3-day voiding diary the Restorative Nurse reviews continent and incontinent episodes and assigns the appropriate Toileting Program based on the diary results. The careplan is updated and individualized using the identified appropriate Toileting ProgramThe Restorative Nurse has been re-educated on this provider's Toileting Programs for bladder	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095			(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/24/2011	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 3 day voiding pattern was completed on 10/16/10 - 10/18/10 and again on 11/20/10 - 11/22/10.  Both patterning records indicated the resident was able to void correctly in the toilet several times during the day, with at least 3 times noted between 7:00 A.M 12:00  PREFIX TAG  PAGE CORRECTIVE ACTOR SHOLLD BE  CAGROS-REFERENCED TO HE APPROPRIATE  DAT  PAGE TAG  P	HERITA	GE PARK			STREET A 2001 H FORT V	IOBSON ROAD		
that the deficient practice does not recur: Upon completion of the 3-day voiding diary the Restorative Nurse reviews continent and incontinent episodes and assigns the appropriate Toileting Program based on the diary results. The careplan is updated and individualized using the identified appropriate Toileting ProgramThe Restorative Nurse has been re-educated on this provider's Toileting Programs for bladder	PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
which is a plan to toilet the resident upon rising, before or after meals, and at bedtime and to check the resident for incontinence throughout the sleeping hours. Thus the resident could potentially be toileting upon rising, before breakfast, and not again till after lunch, approximately 6 hours later and still satisfy the boundaries of the toileting plan. There was no individualized plan to assist the resident maintain as much bladder continence as was possible.  Interview with MDS nurse, LPN #5, and the Director of Nursing, on  which is a plan to toilet the resident add voiding diary including identifying patterns, assigning the appropriate Toileting Program and individualizing/updating the plan of care.Education provided March 17, 2011 by the Director of Nursing ServicesThe DNS/ADNS is responsible for oversight to ensure compliance. The facility toileting program has been modified to ensure there is not an extended period of time between toileting opportunities. The modified toileting program allows that residents appropriate Toileting Plan of care.Education provided March 17, 2011 by the Director of Nursing ServicesThe DNS/ADNS is responsible for oversight to ensure compliance. The facility toileting program has been modified to ensure there is not an extended period of time between toileting opportunities. The modified toileting program all individualized plan to assessing the appropriate Toileting Program and individualizing/updating the plan of care.Education provided March 17, 2011 by the Director of Nursing ServicesThe DNS/ADNS is responsible for oversight to ensure compliance. The facility toileting program has been modified to ensure there is not an extended period of time between toileting program allows that residents appropriate Toileting Program all of care.Education provided March 17, 2011 by the Director of Nursing ServicesThe DNS/ADNS is responsible for oversight to ensure compliance. The facility toileting program has been modified toileting program lows that residents appropriate for Toilet		completed on and again on Both patterning the resident we correctly in the during the day noted between P.M. However placed on toils which is a plate upon rising, be and at bedtimeresident for in throughout the Thus the resident for in throughout the toileting up breakfast, and lunch, approximate and still satisfication that the toileting produced in the	10/16/10 - 10/18/10 11/20/10 - 11/22/10.  Ing records indicated as able to void e toilet several times y, with at least 3 times in 7:00 A.M 12:00 er, the resident was eting program #2, in to toilet the resident efore or after meals, e and to check the continence e sleeping hours. Hent could potentially bon rising, before not again till after imately 6 hours later by the boundaries of lan. There was no l plan to assist the tain as much bladder was possible.			that the deficient practice does not recur: Upon completion of 3-day voiding diary the Restorative Nurse reviews continent and incontinent episodes and assigns the appropriate Toileting Program based on the diary results. The careplan is updated and individualized using the identification appropriate Toileting Program Restorative Nurse has been re-educated on this provider's Toileting Programs for bladder incontinence. Education inclusuit is not limited to assessing 3-day voiding diary including identifying patterns, assigning appropriate Toileting Program individualizing/updating the plas of care. Education provided Ma 17, 2011 by the Director of Nursing Services The DNS/AD is responsible for oversight to ensure compliance. The facility toileting program has been modified to ensure there is not extended period of time between toileting opportunities. The modified toileting program allothat residents appropriate for Toileting Plan #2 will be toileted before or after meals using the following guideline: 1. Resider are toileted upon rising in the A.M.2. Residents residing in a "even" numbered room are toileted before each meal3. Residents residing in an "odd"	ied The des the and an arch NS / t an een ws ed ents	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155095			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY  COMPLETED  02/24/2011	
		155095	B. WIN			02/24/20	J11
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON ROAD FORT WAYNE, IN46805		OBSON ROAD		
	SUMMARY S (EACH DEFICIEN REGULATORY OR  02/24/11 at 10 their opinion, inot display any the Toileting P LPN #5 indica Medicare asse #174's incontint to his discharg the facility's pi worked. There when asked he indicating a re consistently 3 breakfast and incould potentia toileting opport individualized needs and assi attain and/or n level of bladde possible.  2. During the facility, comple between 10:15 MDS nurse, L	tatement of deficiencies cy Must be perceded by full lsc identifying information) :00 A.M. indicated in Resident #174 did y voiding pattern so clan #2 was adequate. Ited on a 60 day ssment, Resident mence improved prior ge from the facility so clan must have e was no response ow a voiding pattern sident voided times between clunch and a plan that clly provide no retunities was to meet the resident's set the resident to maintain the highest er continency  initial tour of the ceted on 02/21/11 G.A.M 11:00 A.M., PN #6 indicated	B. WIN	2001 H		are e d vill e vill e nly x vill	(X5) COMPLETION DATE
	Resident #60 vincontinent, re	quired extensive staff					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		155095	B. WING			02/24/2	011
NAME OF F	PROVIDER OR SUPPLIER		20	01 HC	DDRESS, CITY, STATE, ZIP CODE DBSON ROAD /AYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	assistance for was on toileting	hygiene needs, and ag plan #2.					
	was reviewed A.M. The resist the facility on diagnoses, ince to, dementia, a fibrillation.  The most recess assessment, continent of he extensive staffs hygiene needs cognitively immost recent que completed on the resident was incontinent of quarterly MDS on 09/24/10, in was totally incobladder.	nut full MDS ompleted on 06/10/10, esident was totally er bladder, required assistance for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155095		(X2) MULTIPLE  A. BUILDING  B. WING	CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 02/24/2011		
NAME OF PROV	/IDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON ROAD  FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
fo in as in color in ut sit as id no clare to us fo ce coldi in the Ju we as we are the color in	orm, completed dicated the rest aboth frequent and continent of lateral variations, verifications, verification	ed on 09/18/10, esident was marked atly and totally her bladder, could ad follow erbalize her needs, ght, and maintain a . The resident was being able to ge to urinate, could e toilet or her to toilet herself. The sted as having a left ery and required the xtender, and had the ributing factors:	IAU			DATE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155095			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY  COMPLETED  02/24/2011		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON ROAD  FORT WAYNE, IN46805					
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 3 day voiding pattern, completed from 09/08/10 - 09/10/10 indicated the resident was consistently wet but also voided at 5:00 A.M., 9:00 A.M., 11:00 A.M 12:00 P.M., 3:00 P.M 4:00 P.M., and 7:00 - 8:00 P.M during the non-sleeping hours. However, the resident was placed on toileting plan #2, which did not address the resident's voiding pattern and was not individualized to meet her toileting needs.  Interview with LPN #5 and the Director of Nursing, on 02/25/11 at 10:00 A.M., indicated they did not		P	2001 H	OBSON ROAD	TE	(X5) COMPLETION DATE	
	feel there was any voiding pattern for Resident #60 and they felt toileting plan #2 was adequate to meet the resident's needs.  Review of the facility's policy and procedure, titled, "Bladder Program," dated 03/10 and provided by the Director of Nursing on 02/24/11 at 9:10 A.M. indicated							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/ AND PLAN OF CORRECTION IDENTIFICATIO  155095		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/24/2011	
NAME OF PROVIDER OR SUPPLIER  HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON ROAD  FORT WAYNE, IN46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLI		(X5) COMPLETION DATE
TAG	the following: totally inconting placed on a total resident should changed every voiding pattern develop an inco specific progra plan and reside records/assign voiding pattern determined, re toileted upon re after meals, and There was no presidents on a plan #2 which to not provide meals if a residents	"if a resident is nent and unable to be allet or bedpan, the dibe checked and two hours, if a not can be determined, dividualized resident am, update the care ent care ment sheet, if a not cannot be sident should be rising, before and ad at bedtime"  procedure to place plan such as toileting allowed the potential toileting between dent was toileted eal and not until after	TAG	DEFICIENCY)	RIATE	DATE